A Review of Adult Mental Health Mobile Crisis Programs

Prepared for:
Department of Health and Human Services
Office of Adult Mental Health Services

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CRISIS REVIEW EXECUTIVE SUMMARY

INTRODUCTION

The Maine Mental Health Crisis Services Standards, initially developed by crisis providers and subsequently updated by the Office of Adult Mental Health Services (OAMHS), as specified in the October 2006 Consent Decree Plan, were finalized November 30, 2006. To monitor and ensure compliance with the new standards a regularly scheduled review will be conducted at intervals defined by the OAMHS. This initial year helped develop the content and structure of the review by looking at a small sample from each agency. Subsequent reviews will promote greater consistency in the application of crisis standards statewide, and help clients and family members, as well as those running crisis programs, understand what quality services look like.

This report summarizes the findings of the initial crisis reviews. The reviews provide measurable indicators of current services, highlight areas of strength, and help agencies focus their attention on areas to improve. The information evaluated by the review team included:
- Policies and Procedures Manual(s);
- Documentation of telephone and face-to-face contacts for the last three months;
- Documentation of supervision, training, and licensing and/or certification for all staff;
- Contracts with consultants (if any);
- List of employees;
- Staffing schedules for the previous 2 weeks by shift and provider type, i.e. LCSW, MHRT/CSP, etc.;
- All Memoranda of Understanding with hospitals, law enforcement, etc.

The review team selected by OAMHS was comprised of: Darren Morgan, MDiv, LSW, Region III Team Leader; Naya Blue, LCSW, Office of Consumer Affairs; Katherine Storer, MSW, Office of Consumer Affairs and Cheryl LeBlond, LCSW, Independent Clinical Consultant.

An Adult Mental Health Crisis Standards Protocol was produced in collaboration between the University of Southern Maine's Muskie School of Public Service and the Maine Department of Health and Human Services (DHHS), OAMHS to be used as a standard tool in the review process. The tool reflected the required components of the Crisis Services Standards.

METHODOLOGY

Eleven adult crisis programs were visited and reviewed between November 2007 and January 2008. The agencies reviewed were Aroostook Mental Health Center, Community Health and Counseling Services, Crisis and Counseling, Crisis Services Inc., Evergreen Behavioral Health, Ingraham, Mid-Coast Mental Health Center, Oxford Mental Health Services, Sweetser, Tri-County Mental Health Center, and Washington County Psychotherapy Associates.

The reviewers randomly selected and evaluated a total of 587 single crisis event telephone contacts. Sixty-seven single crisis event face-to-face assessments were reviewed. The reviewers focused on crisis services that occurred within a three-month timeframe preceding the scheduled visit. In addition, the team also conducted a random chart review of a limited number of records using a

modified tracer methodology – "tracing" the record from point of entry (phone contact) through assessment, stabilization and outcome recommendations and/or referrals. The tracer process focused on crisis services that were conducted within 48 hours of the review visit. The 33 clinical records that were reviewed using the tracer format represent a small random sample rather than a scientific sample.

FINDINGS

Crisis services throughout the state all operate with the same basic premise of screen, assess and assist the client to an immediate resolution. From there providers have differences in providing stabilization, intervention, and other aspects of crisis work. The review team found that in terms of compliance with the standards, all providers need to improve in the following areas: documentation, the use of crisis plans, updating Memoranda of Understanding (MOU), capturing the consumer perspective, collaborating with others, and supervision. In addition, findings indicate that the use of emergency departments warrants additional investigation.

Documentation
Telephone contacts appeared to have the least documentation and often did not meet all of the components outlined in the Crisis Standards. Most commonly missing from the telephone clinical notes were risk factors, the specific intervention used, and the evaluation of the intervention. Descriptions of the presenting problems were recorded 100% for 10 agencies and 95% for one agency.

The style in which clinical notes were written often did not capture the perspective of the consumer. Often an added sentence or two could provide context for the complete crisis intervention that has occurred and provide additional insight into the quality of service being provided. Notes that contained direct quotes from the client appeared to best reflect the consumer perspective. Some providers had adapted a good practice of asking the client's wishes and documenting the desired outcome. In cases where the wishes and outcome did not match, an explanation for the inconsistency was recorded. In all cases where a documented disconnect occurred, the reason for a different outcome was clinically indicated.

Crisis Plans
The review team examined face-to-face documentation to determine whether it included a crisis plan, whether an existing crisis plan was utilized during the crisis contact, and whether a crisis plan that was developed was shared with other providers. Crisis plans were not consistently used. Only one team asked 100% of the time if a crisis plan existed. Another six teams asked an average of 45% of the time.

Seven of 11 teams did not utilize the crisis plan during the crisis contact. Of the four teams that used a crisis plan, only 28% shared the plan with providers. The majority of teams stated that they do not refer to crisis plans. The common reason for not screening for crisis plans is because the opportune time for implementing the crisis plan has passed when the client is calling or seeing the crisis provider; by then, the person is experiencing a higher level of acuity.

Memoranda of Understanding

The content of the MOUs widely varied. Ten of 11 teams had existing MOUs for hospitals and all consistently included sharing of information and clear channels of communication. The majority of the MOUs address liability issues and do not identify the expectations of each entity. The Rapid Response Protocol and performance goals that are outlined in the standards were also consistently missing from the MOUs. Six teams complied with the standard requiring law enforcement MOUs. Many MOUs have not been updated to reflect the current components listed in the standards. Some MOUs were automatically renewed and, therefore, had not been reviewed in years. In addition to the standard that requires a quarterly meeting to discuss issues of concern, an annual meeting may be arranged to ensure that all participants are still in agreement.

Clinical Forms

The review team recognized a connection between a provider's assessment forms and the quality of the crisis assessment. Forms that asked specific questions from the crisis standards were in greater compliance than those that relied on clinicians to remember questions. Sections of the forms appeared to be completed to the level required by DHHS licensing. Clinically, forms were often lacking contextual detail. Among the forms reviewed, the most effective form was designed to assume that the crisis standards were being met unless otherwise documented; it also incorporated many quotes from clients. This format appeared to represent a level of quality and professionalism.

MHRT/CSP

The new Mental Health Rehabilitation Technician/Crisis Services Provider (MHRT/CSP) certification was implemented April 2007. Agencies were given until April 2008 to fully credential tenured crisis staff. New staff hired after April 1, 2007 were expected to be fully credentialed prior to working independently, as cited in the MHRT/CSP Certification Requirements. Many of the crisis providers are currently conducting the crisis curriculum training. Data collected during the review process provide a snapshot of MHRT/CSP implementation. At the time of this review, approximately 25% of the 278 crisis staff identified by the Maine Crisis Services Network had already received their MHRT/CSP. Since April 1, 2007, 63% of new staff hired were MHRT/CSP certified.

Quality Service

Solid documentation appeared to be the key to gaining insight into quality service. In cases where documentation was minimal, review team members asked follow up questions to the staff to help complete the whole story and the unfolding of events. Consumers and crisis constituents were not interviewed during this process. In most cases the actual practice was consistent with quality service, although the documentation was unclear. Quality service includes documentation that is clear, thorough and concise. Effective documentation includes the consumer's perspective, the lowest level of clinically indicated intervention, efforts to connect clients to natural and professional supports, assisting in referrals to appropriate services that address ongoing needs, and providing immediate intervention that includes an interim plan to help resolve the current crisis. In addition, quality service was observed through notes that recorded reasons for missing information or an intervention that was inconsistent with the presenting problem or diagnosis. Through this style of documentation, it was clear that questions were being asked and certain considerations had occurred, which created thorough clinical notes without being verbose.

The majority of crisis staff practiced what was in the agencies' written policies and procedures. In situations where practice did not comply with the crisis standards, reviewers often found that the

agency did not have a policy or procedure to reflect the standard. A few crisis programs wrote their procedures according to the crisis standards. This appeared to make it easier for providers to monitor adherence to the standards.

Supervision
Seven of the 11 crisis programs meet the crisis standard for supervision. However, the majority of crisis providers inquired about a best practice to fulfill the face-to-face supervision requirements.

Emergency Departments
During one crisis review visit, the review team saw an overwhelming number of assessments conducted in the Emergency Department (ED). The respective crisis provider stated that it was their common practice to see clients in the ED, and that they were essentially the consult for the hospital. This led to a line of questioning from the reviewers to understand why so many clients were seen inside the ED despite the clinical presentation and eventual disposition. As the reviewers moved throughout the state it became clear that the use of EDs is a complex issue that impacts consumers and the system as a whole.

The Maine Mental Health Crisis Service Standards and the review protocol included questions to determine whether crisis providers offer consumers the least restrictive level of intervention, and whether they assist consumers in remaining in a community environment whenever possible. Some of the modified tracer reviews provided an opportunity to learn about practices in this area. In six of the 11 reviewed cases for "Face to Face Evaluation Seen in the ER which started as a Telephone Call," crisis had no involvement in the decision to determine the site of the assessment. Two of the 11 directed the client to the ED based on the phone presentation and prediction that the client would require hospitalization. One of the 11 had clear information that medical intervention was necessary, and two cases had no documentation as to why the client was sent to the ED.

The crisis review team found that there seems to be an understanding among crisis providers and the communities that medical clearance from an ED is required for a psychiatric admission. As a result, crisis workers are reluctant to see clients outside of the ED, especially if it appears the disposition will be hospitalization.

At one agency a live example played out while the reviewers were present. A crisis worker received a call from a concerned doctor requesting that they come to the doctor's office to assess his patient. The crisis worker went to the office as requested and determined the client needed inpatient hospitalization. The crisis worker found one hospital with an available bed; however, the hospital refused to admit the person without a medical clearance through the ED. The person was then transported approximately an hour away to the nearest ED for medical clearance. Ironically, the ED doctor who authorized medical clearance was the same doctor who had seen the person a few hours earlier in his office.

There are both commonalities and differences among practices used by crisis providers related to Emergency Departments. The crisis review team found documentation that most providers offer least restrictive methods to resolve crises both through phone calls and face-to-face assessments outside of the ED. However, the review team observed different approaches used by providers such as acting as an answering service and referring people to the ED despite opportunities for clinical intervention over the phone, requiring a supervisor's permission to see a person in the home, or requiring that a police officer accompany two crisis workers to the home in efforts to avoid the ED.

Crisis providers appear to be influenced by a number of factors when making their decision regarding the location of an assessment. These include: consumer's choice, best practice for clinical presentation, safety/risk factors, staff experience and availability, predicted disposition, time of day, and prior experience with a client.

The crisis review team also found that the community plays an important role in how well crisis providers can accommodate clients outside of the ED. For example, police are sometimes reluctant to accompany crisis unless there is a stated or concrete safety concern. In addition, crisis providers face several conflicting interests that influence the use of Emergency Departments. These include the need to perform quality service, meet requirements for response times, honor client's choice of location and disposition, consider safety issues, decide best use of crisis staffing levels, and determine availability and responsiveness of police. It should be noted that often crisis programs are not involved in the decision to use the ED as the location for the assessment. Other entities or the consumers themselves often make that decision. It is also noteworthy that one crisis program reported a recent change whereby community members call crisis first to determine if an ED setting is truly necessary.

The crisis review team asked crisis providers about their understanding of the Maine Mental Health Commitment Law, especially Title 34-B, Section 3863 that refers to the legal limits to holding someone involuntary beyond 18 hours in the emergency department while awaiting a psychiatric hospitalization. The results were mixed. The majority of programs believed that a documented crisis reassessment was sufficient and the hold could legally continue. Providers also reported that this situation occurs infrequently. It was clear that knowledge about the law and amendments are critical, and that providers had additional questions in order to carry out clinically sound service.

In conclusion, although many crisis teams attempt to use the least restrictive setting for assessments and practice their stated policies, crisis performance indicator reports show that assessments in the ED are greater than those outside of the ED.

Individual Strengths Identified
The review team found many examples of positive work provided through crisis programs. While some of the highlights were observed in more than one provider, most were unique to individual teams and were seen by the reviewers as evidence of quality service that could be shared across programs.

- Supervision tracking form that captured active supervision not otherwise documented
- Clear, concise, user-friendly policies on documentation and supervision
- Clear and organized handbook that outlines how to perform crisis responsibilities including useful tips on unique crisis situations/relationships
- Quality practice of least restrictive settings, including both the practice and documentation of effort towards seeing consumers outside of the Emergency Department (ED)
- Crisis plans that were consistently complete, easy to access and used as a reference.
- Clear, thorough and professionally written clinical documents
- Evidence of regular communication and collaboration with providers
- A disposition narrative that used a timeline format, which made it very clear to follow the overall crisis event and unraveling of the intervention

- Individualized interventions that were consistent with the presenting problem, diagnosis and history
- Evidence of consumer perspective and addressing the client's wishes whether they could be met or not
- Resource board centrally located for crisis staff, updated and easily accessible
- Active use of the Site Determination Grid
- Evidence of active intervention that moves the client out of the acute crisis phase, supports them out of the crisis phase, provides follow up and ensures connection to services with the consumer's participation.
- Excellent telephone contact form, face-to-face assessment form and outcome recommendation forms

RECOMMENDATIONS

Recommendations are based upon what was found in the small sample review.

Recommendations Pertaining to Providers and Overall Crisis Service System

Crisis Plans
1. Create a consistent practice of post-crisis planning and/or creating a time for the client to come back in for preventive crisis planning.
2. Consider data collection to reflect calls from clients regarding preventive crisis planning.
3. Provide training for providers on crisis planning, specifically addressing the use of crisis plans during a crisis event that respects consumers identified wishes.

Memoranda of Understanding
4. Create a mechanism that will ensure that (1) all agreements reflect current requirements and (2) participants are still in agreement to the current practice and expectations. Require a renewal signature at regular intervals.
5. MOUs with community services should include a provision for the crisis provider to be involved in deciding the location for the assessment.

Emergency Departments
6. Work closely with hospital systems for flexibility to safely admit patients from physician offices and other venues outside of the emergency departments.
7. Increase NAMI's evidenced-based Crisis Intervention Teams (CIT) for law enforcement statewide, which can reduce ED visits and have better outcomes for the consumer.
8. Devise stronger MOUs in each community with all vital community entities that have an impact on ED visits.
9. Revisit the Rapid Response protocol to redefine the purpose and improve outcomes.
10. Further investigate to identify the complex systemic issues related to widespread use of the ED for assessments. The investigation should result in development of a plan to address issues uncovered.
11. Further investigate components needed to create a culture where community providers call the crisis provider at the beginning of a crisis event to determine the site of assessment.

Documentation

12. Provide documentation refreshers for clinical staff.

Supervision

13. Develop a model system to record supervision and share it with providers.

Recommendations Pertaining to Crisis Review Tool, Process and Standards

Review Tool

14. Modify the review tool based on feedback from the review team and providers. Focus on the standards as written and quality indicators.
15. Identify quality indicators included in the review tool that are outside the written standards.
16. Define what constitutes unacceptable, acceptable and exceptional levels of compliance and develop a system by which crisis standards are assigned a value for overall calculations.

Review Process

17. Review a larger sample of records and focus on quality of service using the modified tracer methodology.
18. Conduct future reviews using a team of reviewers that represent a consumer, clinician and OAMHS representative, as was done in this initial review process.
19. Before the next round of reviews, give providers clear information about the review process, including documentation needed during the review and outline the follow up process thereafter.
20. Establish a follow up protocol for corrective action plans addressing areas identified as deficient.
21. Include the agencies individual crisis review results in the contract review process.
22. Create a standard format for individual summary reports that more closely follows the components of the review.
23. Conduct a review of the Adult CSUs using a similar review tool template.
24. End each review visit with a debrief/learning opportunity for feedback to and from the crisis providers for the opportunity for clarification, as was done in this initial review process.

Crisis Standards

25. Update the Crisis Standards to reflect changes needed based on this review.
26. Refine the Crisis Standards to promote more consistent interpretation across crisis providers.

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